The Scope and Responsibility of Medicine

A Forum with a Purpose

To engender discussion of what the scope and responsibility of medicine ought to be in today's society, CALIFORNIA MEDICINE *printed in its June issue six essays by authors known to have keen if various interest in the subject.*

In presenting the essays the editors expressed hope that they would be the beginning of a forum from which a definition of our profession's responsibilities may be distilled. Readers were invited to take part in a continuation of the forum in succeeding issues. Following are two contributions selected from those received to date. Others will be published in the months ahead.

If you have thoughts on the subject, just address them to the editors of CALIFORNIA MEDICINE, *693 Sutter Street, San Francisco, California 94102. Keep your essays short, please.*

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YOUR SERIES ON THE scope and responsibility of medicine has been eye-opening, stimulating, revealing, and extremely useful to all of us. Anything added at this point must certainly be repetitious, but possibly the following may give emphasis.

The scope of medicine is almost as broad as life; the responsibility is a created charge. The scope of medicine reaches from all of the facets of the healing of the sick to the creation of a health environment for people. It reaches to those matters affecting health such as nutrition, housing, the pressures of life, be they created in rural or urban areas, and even the inputs to our minds. Of all of these as physicians we must be aware, have opinions and, where pertinent, use our talents.

Medicine might be said to have four degrees of responsibility pertaining to this scope. First, medicine has the responsibility for the care of the sick wherever they are or should be. Medicine is responsible for keeping people well through direct intervention, through education, or by its impact in obtaining a healthy environment. Medicine is responsible for returning people to an optimum stage of well-being following illness. Second, in these days of tumultuous scientific advance, medicine is responsible through institutions and organizations for the maintenance and elevation of the level of professional care, the continuing education and re-education of all physicians. Similarly, medicine is responsible for searching out newer and better ways of delivering health care to the people, not only to the poor but to that self-supporting backbone of America who also wait. Third, medicine must be aware of its close relationship to the allied health professions. It must strengthen them and work cooperatively, warmly, and effectively with them. Medicine is responsible for educating patients and the public, voters, and lawmakers about the needs relating to health.

Congress has voted medical care to 30 or 40 million people who formerly had little or none. We must develop means and methods for caring for these people. Somebody with an eye blind to statistics has suggested that these people be brought into the so-called mainstream of medical care. If this were to be done equitably, and one knows well that it couldn't be, it would average out to 15 hours a week of added work for every man active in the practice of medicine. Since he is now averaging about 65 hours a week, one will have to find a different solution to this problem long before existing or new medical schools can add appreciably to the number of doctors practicing medicine.

Fourth, medicine must look about to those things that affect health, but which are not directly in medicine, and in this area it must have an opinion, collective to a degree and individual. This is the area of education, housing, nutrition, circumstances of work, travel and the many, many factors that make living in a large urban environment increasingly difficult and unhealthy.

If we agree that the scope of medicine covers these four areas, then we can assume our individual responsibilities for that which comes within our purview—we can support those problems which as a profession we should be supporting and exploring, we can urge others better qualified to apply themselves to the problems that affect health but are certainly not problems for our expertise, and finally, we must be aware of problems beyond these and have opinions when they are discussed.

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LESS THAN FIFTY YEARS AGO, at graduation the medical student was presumed to be equipped for general practice without being limited in his future practice with regard to surgery, obstetrics or the minor specialties. An internship was not obligatory as a preliminary to practice. Many of these graduates entered general practice and attempted almost every type of medical care without any special restrictions—many served acceptably and sometimes with distinction.

Today, at the end of four years the medical student is not equipped for any field of specialized patient care, much less for general practice as it used to be known. The general practitioner is a vanishing breed, especially because of the restriction in access to hospitals for surgical and obstetrical care (except for those with specialty training).

There is now a distinct impetus or at least a pious hope toward developing practitioners who are "family physicians" who will have advanced training in medicine, pediatrics, and general patient care excluding surgery and obstetrics. In effect, these men will cover only the broad field of medicine and pediatrics. (Incidentally, if a classically-derived name could be developed for "the family physician" or "the primary physician," as with orthopedics, pediatrics, ephebiatrics, etc., it might improve the image of this form of practice.)

Recently many schools have attempted to indoctrinate students for this type of comprehensive family care by a special emphasis in the medical curriculum. Many great teachers of the past had the capacity to teach the personal attributes of medical care by example, but many of them are now being lost to molecular biology and the super-specialties. Lectures by psychiatrists and sociologists are not the complete substitute for the teaching of empathy and the personalization of medical care as taught by example.

Orientation toward specialty practice has, at the same time, been pushed back to the early years of medical training when the student may set out to be simply a super-specialist and remain completely indifferent to the need to become a "physician." For example: the student who is determined to become a surgeon may be taught to resort to the psychiatrist if human problems intrude into his technical field, although it is unfair to single out the surgeons. It is worthwhile to point out that, in the past, there have been great physicians in almost every specialty, but this proportion is now dwindling.

Medical schools are not primarily institutes for scientific research or for specialty training below the level of postgraduate education, but unless scientific research and specialty training continue to be strong and essential components of the medical school, they would simply become trade schools with no possibility to contribute to advances in scientific medicine or the development of the specialties—a most dismal and undesirable prospect.

The responsibility of medical schools should be to prepare every student for total patient care within the limits of his personal expertise so that at graduation he would be well-oriented toward all the problems of the patient no matter what special field he finally enters. This concept is as fundamental as the knowledge of gross anatomy to an M.D. The addition of advanced knowledge to the two years devoted to basic science 50 years ago would now require a full four years.

Students could be given this basic education without less emphasis on the basic sciences or neglect of the specialties. They would find time for their special interests; Franklin Delano Roosevelt found time for his stamp collection. Postgraduate education must continue to be an essential part of the medical school, but this should prepare the student for specialty practice, for research, for a career in education, or for family practice. The medical graduate should be a physician with the attributes of human and social consciousness, with empathy and understanding of family and economic situations. His future involvement in research, teaching or family practice should be an extension of his exposure to good teaching, to faculty example and finally, to his own special interests. The student who develops into a surgeon may never do more than hold a retractor in his undergraduate days, but it is the obligation of the school to teach him the fundamental aspects of caring for *people* rather than *patients* before he goes on to specialty training.

An afterthought of what has been said is obviously the product of my own preoccupation with pediatrics. The child is a perfect paradigm of patient care: his problems are often uncomplicated, his history involves his prenatal status, his family background, and his socio-economic situation. He is the patient best suited for initiation of medical students at an early stage of training into all the human aspects of patient care rather than the elderly, complicated, and uncooperative adult patients who form so large a proportion of student case-teaching material.

More emphasis on the child patient for student teaching would be a most useful component for fundamental training in every aspect of practice. Years ago, an elderly golf pro said, "You shouldn't start teaching golf with a driver or much less with a wedge; start out with a putter and slowly work up." Such a principle might readily be acceptable in the training of the medical student. The use of pediatric patients to a greater extent in teaching would necessitate expansion of inpatient and outpatient child care facilities. It must be remembered, however, that if the family physician is to be an increasing factor in the medical care of the population and if his development is to be an important responsibility of the medical school, nearly half of his patients will be children or adolescents. Adequate pediatric training, therefore, should be an important ingredient of routine medical education. Above all, what is learned about the care of the child patient may be the most useful orientation a medical student has for care of patients of all ages.